FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or if redesignated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17063 — **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** — 17057

1. PLACE OF DEATH
a. COUNTY: Charles — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaPlata Md
c. LENGTH OF STAY IN 1b: 12-Hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Physicians Memorial LaPlata Md

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Mt.Victoria Md — Charles Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 08.1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First James Middle Lee Last Bailey
4. DATE OF DEATH: Month 12 Day 23 Year 19 66

5. SEX: Male
6. COLOR OR RACE: W-US
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8-2-1908
9. AGE (In years last birthday) 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Mt.Victoria Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Bailey
14. MOTHER'S MAIDEN NAME: Florence Lucas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 218-2004-77
17. INFORMANT: Mrs James Goldsmit-Aunt — Address: Mt.Victoria Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Injuries Multiple Extreme — INTERVAL BETWEEN ONSET AND DEATH: 17-Hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Being Run Over By A Tractor& Trailer
DUE TO
(c):

812.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Skull-Fracture Ribs, Ruptured Spleem

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): was run over by a tractor & Trailer
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 12-22-66
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Mt Victoria Md (County) Charles Co (State)

21. **I certify** that I took charge of the remains described above, held an Autapsy [ ], Inspection [X], Inquiry [X], and in my opinian death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): James E.Andrews MD, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county): Indian Head Md.
22. DATE SIGNED: 12-24-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec.27,1966
23c. NAME OF CEMETERY OR CREMATORY: Christ Church
23d. LOCATION (City or Town) Wayside, (County) Charles co., (State) Md.

24. FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home Inc., La Plata, Md.
25a. REC'D BY REGISTRAR — DATE: JAN 3 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 6M 1/66

1

FOR STATE HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, as the case may be. Any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17064

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17058

1. PLACE OF DEATH
   a. COUNTY: Charles — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wicomico (Rural)
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Charles
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wicomico (Rural)
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First GEOFFREY — Middle DAWES — Last BAKER

4. DATE OF DEATH: Month December — Day 1 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH (1901): April 9, 1907

9. AGE (In years lost birthday): 65 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Editorial

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (State or foreign country): Lynn Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry M. Baker.

14. MOTHER'S MAIDEN NAME: Lynette Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Lynette Cave — Address: North Canton, Mass.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease.
   DUE TO
   (b):
   DUE TO
   (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221

   INTERVAL BETWEEN ONSET AND DEATH

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 12/2/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 12/8/66.

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

23d. LOCATION (City or Town) (County) (State): Suitland, Md.

24. FUNERAL DIRECTOR: Archard Funeral Home — ADDRESS: La Plata, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 15 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17065

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17059

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wicomico (Rural)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wicomico (Rural) 08-1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

00

3. NAME OF DECEASED (Type or print): First LYNETTE — Middle E. — Last BAKER

4. DATE OF DEATH: Month December — Day 1 — Year 19 66

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: July 2, 1876

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Lynn Mass.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Henry Moore.

14. MOTHER'S MAIDEN NAME: Florence Dawes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: UNKOWN

17. INFORMANT: Mrs. Lynette E. Cave — Address: North Carolina

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]
Address (Street, city, town, or county)

22. DATE SIGNED: 12/2/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 12/8/66

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

23d. LOCATION (City or Town) (County) (State): Smithland Md

24. FUNERAL DIRECTOR: Orchard Funeral Home — ADDRESS: La Plata, Md

25a. REC'D BY REGISTRAR DATE: DEC 15 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (9) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17066 17060

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, but in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, say write RURAL and give nearest town): Patuxent River, Benedict
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Patuxent River

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Benedict 08.1
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Randall — Middle: Eugene — Last: Bland

4. DATE OF DEATH: Month: December — Day: 8, — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 11, 1947

9. AGE (In years last birthday): 19 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): State Road

10b. KIND OF BUSINESS OR INDUSTRY: Maryland

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eugene Lawrence Bland

14. MOTHER'S MAIDEN NAME: Jessie Marie Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Father — Address: same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
929.8 IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: 12-8-66
DUE TO (b): While duck hunting, boat broke away
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): and he tried to swim to retrieve it

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Patuxent R; Duck hunting when boat got loose

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 12 8 196

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Patuxent R

20f. (City or town) (County) (State): Benedict Chas Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Edelen M.D.
EXAMINER'S NAME (Type): Edward J. Edelen M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 12-9-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-11-66

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer

23d. LOCATION (City or Town) (County) (State): Great Mills, Maryland

24. FUNERAL DIRECTOR — ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 12 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17067

CERTIFICATE OF DEATH

18056

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 18.1
d. STREET ADDRESS: St. Rt. 3 La Plata.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First STEVEN Middle ALEXANDER Last CHESLEY

4. DATE OF DEATH: Month Dec Day 30 Year 1966

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 15 Aug 66
9. AGE (In years last birthday) ____ yrs. IF UNDER 1 YEAR Months 4 Days 15 IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): CHARLES Co. Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: THOMAS O. CHESLEY
14. MOTHER'S MAIDEN NAME: JULIA FARMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: JULIA CHESLEY Address: LAPLATA Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO (b): Bronchitis — 7 days
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
501X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 27 Dec, 1966, to 30 Dec, 1966, that (I) (we) last saw the deceased alive on 30 Dec 1966, and that death occurred at 2:04 M, from causes and on the date stated above.

22a. SIGNATURE: A Woody — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 30 Dec 66
22c. PHYSICIAN'S NAME (Type): ARTHUR O. WOODDY
22d. ADDRESS: JARWOOD CLINIC LA PLATA, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-30-66
23c. NAME OF CEMETERY OR CREMATORY: ST. MARYS
23d. LOCATION (City or Town) (County) (State): NEW PORT CHAS Md

24. FUNERAL DIRECTOR: Linkous — ADDRESS: La Plata Md
25a. REC'D BY REGISTRAR DATE: JAN 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

IO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME 5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17068 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 17061

1. PLACE OF DEATH
e. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dentsville (Dentsville) Rural
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dentsville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Russell Last: Cooley
4. DATE OF DEATH: Month: 12 Day: 21 Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 13, 1924
9. AGE (In years last birthday): 42 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic- Refrigeration
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): W.Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William C. Cooley
14. MOTHER'S MAIDEN NAME: Maude E. King
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW2
16. SOCIAL SECURITY NO.: Unkown
17. INFORMANT Address: Bettie Cooley, Rt. 3, La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Ruptured wound of chest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Handling gun
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 12-21-66 / 12-21-66

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Was apparently drunk at time of accident
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Was cleaning gun

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 12-21-66
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Residence
20f. (City or town): Dentsville (County): Chas (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Hodeen
EXAMINER'S NAME (Type): T. S. Hodges M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county): La Plata, Md.
DATE SIGNED: 12-21-66

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 26, 1966
22c. NAME OF CEMETERY OR CREMATORY: Trinity Mem. Gardens
22d. LOCATION (City, town, or county) (State): Waldorf, Charles Co., Md.

23. FUNERAL DIRECTOR ADDRESS: Arehart Funeral Home Inc., La Plata, Md.
24c. REC'D BY REGISTRAR DATE: DEC 30 1966
24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

17069 — Reg. Dist. No. 17062

1 PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WALDORF
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ST CHARLES CLINIC

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WALDORF
d. STREET ADDRESS: P.O. BOX 124
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First RONALD — Middle LEMOIN — Last HARMON

4. DATE OF DEATH: Month 12 — Day 12 — Year 1966

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
MALE	CAU.	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	SEPT. 26, 1909	57 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PROGRAM ANALYST	U.S. GOVT	NEBRASKA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM C. HARMON	JULIA GOODENBERGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
NO	506-05-1778	THELMA HARMON, BOX 124, WALDORF, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	4 HOURS
DUE TO (b)	ARTERIOSCLEROTIC HEART DISEASE	>2 YEARS
DUE TO (c)	HYPERTENSION	>2 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): AORTIC VALVE DISEASE, PROBABLY ARTERIOSCLEROTIC

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/19/66 to DEATH, 19____, that I last saw the deceased alive on 11/23, 1966, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Merkle M.D. — ADDRESS (Street, city or town, state): ST CHARLES CLINIC — DATE SIGNED: 12-12-66

PHYSICIAN'S NAME (Type): ROBERT W. MERKLE — WALDORF, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	12-16-66	OAKLAND CEM.	WALDORF, MD.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
The Hunt Funeral Home, Waldorf, Md.	DEC 19 1966	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17070

CERTIFICATE OF DEATH

17069

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicans Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: New York — b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bridgeport 693
d. STREET ADDRESS: R.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle C. Last HEFFRON

4. DATE OF DEATH: Month 12 Day 12 Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-2-1894

9. AGE (In years last birthday): 72 yrs

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Manager

10b. KIND OF BUSINESS OR INDUSTRY: Borden Milk Co.

11. BIRTHPLACE (County & State, or foreign country): Middleton, New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 029-85-9182

17. INFORMANT: May Bell Heffron -Wife — Address: New York Bridgeport,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Toxic gangrene left foot — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): bleeding peptic ulcer — 4 mths.
DUE TO (c): lobar pneumonia — 6 mths
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-22, 1966, to 12-12, 1966, that (I) (we) last saw the deceased alive on 12-12 1966, and that death occurred at Midnight from causes and on the date stated above.

22a. SIGNATURE: F M Johnson M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-13-66

22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON MD

22d. ADDRESS: LA PLATA, Md. 20646

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/15/1966

23c. NAME OF CEMETERY OR CREMATORY: Moringside Cemetery

23d. LOCATION (City or Town) (County) (State): Syracuse, New York

24. FUNERAL DIRECTOR: Goddard&Crandall Funeral Home Syracuse, ADDRESS: 3111 James Street, N.Y.

25a. REC'D BY REGISTRAR DATE: DEC 19 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17071 17064

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): IRONSIDES
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RT 1 LAPLATA (RURAL)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARCHie Middle Lee Last JOHNSON
4. DATE OF DEATH: Month 12 Day 16 Year 1966
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE? 1905
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY: HOME CONSTR.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM JOHNSON
14. MOTHER'S MAIDEN NAME: ELLEN MASON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 216-12-3256
17. INFORMANT: JOHN JOHNSON Address: LA PLATA, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12-16-66
DUE TO (b): Gen Arter Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 4701

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E.J. Edelen M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-16-66
EXAMINER'S NAME (Type): E.J. EDELEN, LAPLATA, MD
Address (Street, city, town, or county) (State)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12-20-66
22c. NAME OF CEMETERY OR CREMATORY: OLD DURHAM CEM.
22d. LOCATION (City, town, or county): IRONSIDES MD.

23. FUNERAL DIRECTOR ADDRESS: The Hunt Funeral Home, Waldorf, Md.
24a. REC'D BY REGISTRAR DATE: DEC 22 1966
24b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
5M 1/63

(M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17065

1 PLACE OF DEATH a. COUNTY: CHARLES, MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: VA b. COUNTY: CAROLINE

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAPLATA

c LENGTH OF STAY IN 1b:

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PORT ROYAL

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physician Memorial Hosp.

d STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: JOYCE Middle: ANN Last: KAY

4 DATE OF DEATH Month: 12 Day: 7 Year: 1966

5 SEX: Female

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Oct 8, 1942

9 AGE (In years last birthday): 24 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RECEPTIONIST

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): VA

12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: LINWOOD KAY

14. MOTHER'S MAIDEN NAME: GRACIE Collawn

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes give war or dates of service)

16 SOCIAL SECURITY NO.:

17 INFORMANT / Address: MANN FUNERAL Home, Bowling Green VA.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) [illegible]

DUE TO (b) [illegible] — INTERVAL BETWEEN ONSET AND DEATH: 12-7-66

DUE TO (c) [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) [illegible]

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 11 pm 12-7-1966

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [illegible]

20f (City or town) (County) (State) [illegible]

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [illegible] M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐

22. DATE SIGNED: 12-8-66

EXAMINER'S NAME (Type): [illegible]

Address (Street, city, town, or county)

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 12-11-66

23c NAME OF CEMETERY OR CREMATORY: GREEN LAWN

23d LOCATION (City or Town) (County) (State): BOWLING GREEN, CAROLINE, VA.

24 FUNERAL DIRECTOR / ADDRESS: MANN FUNERAL Home, BOWLING GREEN VA.

25a REC'D BY REGISTRAR DATE: DEC 12 1966

25b REGISTRAR'S SIGNATURE: [illegible] Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17073 17066

1 PLACE OF DEATH
a. COUNTY CHARLES MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA
c. LENGTH OF STAY IN 1b 2 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PHYSICIANS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE MARYLAND b COUNTY CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COBB ISLAND
d. STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First GEORGE Middle Samuel Last LANDIS
4. DATE OF DEATH Month DEC Day 2 Year 1966
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH 9 Nov 1899
9. AGE (In years last birthday) 67 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ret. Mechanic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country) Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE M. LANDIS
14. MOTHER'S MAIDEN NAME Margaret Terise Shugrus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO 279-10-6831
17. INFORMANT GEORGE M. LANDIS II Address 923 GRANDIN AVE ROCKVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Collapse — INTERVAL BETWEEN ONSET AND DEATH 1 Day
DUE TO (b) Myocardial infarction & fracture — 7 Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) —

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 30 Nov, 1966, to 2 Dec, 1966 that (I) (we) last saw the deceased alive on 2 Dec 1966, and that death occurred at 6:25 PM, from causes and on the date stated above.

22a. SIGNATURE [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 2 Dec 66
22c. PHYSICIAN'S NAME (Type) ARTHUR C. WOODDY
22d. ADDRESS JARWOOD CLINIC, LA PLATA, MD

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE THEREOF 12/6/66
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.
23d. LOCATION (City or Town) (County) (State) Ft Myer, Va.

24. FUNERAL DIRECTOR The J.H. Nine Co.
ADDRESS 2901 14th ST. NW.
25a. REC'D BY REGISTRAR DATE DEC 5 1966
25b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If so, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17074

CERTIFICATE OF DEATH

17067

1 PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicians Memorial Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALFRED — Middle: E. — Last: LEY

4. DATE OF DEATH: Month: Dec — Day: 24 — Year: 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 21, 1880

9. AGE (In years last birthday): 86 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardening-Nursery-Flowers

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): England

12. CITIZEN OF WHAT COUNTRY: Great Britain

13. FATHER'S NAME: John H. Ley

14. MOTHER'S MAIDEN NAME: Louisa King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Unkown

17. INFORMANT — Address: Mrs. Merion McKenna-Neice Phil., Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b):
DUE TO (c):
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-10, 1966 to 12-24, 1966, that (I) (we) last saw the deceased alive on 12-24 1966, and that death occurred at 7:10 M, from causes and on the date stated above.

22a. SIGNATURE: F M Johnson — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-24-66

22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D.

22d. ADDRESS: LA PLATA, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 29, 1966

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City or Town) (County) (State): Suitland Md.

24. FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home Inc., La Plata, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 3 1967

25b. REGISTRAR'S SIGNATURE:

1 (IVi)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17075

CERTIFICATE OF DEATH

17068

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PHYSICIANS MEMORIAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LINDA Middle "URON" Last MAYER

4. DATE OF DEATH: Month Dec Day 7 Year 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 26 Sept 1881

9. AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HW

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Prince George Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel T. Uron

14. MOTHER'S MAIDEN NAME: Clara Seltzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: 218-54-5642-T

17. INFORMANT: Wm. H. Mayer Jr., Address: La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Hypertension arteriosclerotic heart dis. — 5 years
DUE TO (c): Generalized senility.
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 24 Nov 66, 19 66, to 7 Dec, 19 66, that (I) (~~we~~) last saw the deceased alive on 7 Dec 19 66 and that death occurred at 10 P M, from causes and on the date stated above.

22a. SIGNATURE: A. Wooddy MD — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7 Dec 66

22c. PHYSICIAN'S NAME (Type): ARTHUR O. WOODDY

22d. ADDRESS: La Plata. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-10-66

23c. NAME OF CEMETERY OR CREMATORY: Mt. Rest Cemetery

23d. LOCATION (City or Town) (County) (State): La Plata, Charles, Md.

24. FUNERAL DIRECTOR ADDRESS: Arehart Funeral Home Inc., La Plata, Md.

25a. REC'D BY REGISTRAR DATE: DEC 12 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17076

CERTIFICATE OF DEATH

17069

1 PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicians Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cora — Middle: — Last: McDonald

4. DATE OF DEATH: Month: Dec — Day: 6 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-10-1900

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): W.Va

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Oscar Nester

14. MOTHER'S MAIDEN NAME: Sophia Stalnaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO: 232-10-6386B

17. INFORMANT: Mary Price — Address: La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA
DUE TO (b): Gen. Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 331X

INTERVAL BETWEEN ONSET AND DEATH: 5 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-1, 19 66 to 12-6, 19 66 that (I) (we) last saw the deceased alive on 12-6 19 66, and that death occurred at 7:15 M, from causes and on the date stated above.

22a. SIGNATURE: Arturo M. Monteiro, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 12-7-66

22c. PHYSICIAN'S NAME (Type): Arturo M. Monteiro

22d. ADDRESS: P O Box 507 La Plata, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-7-66

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City or Town) (County) (State): Parsons, Tucker, W.Va.

24. FUNERAL DIRECTOR — ADDRESS: Greenlief Funeral Home, Parsons, W.Va.

25a. REC'D BY REGISTRAR DATE: DEC 12 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17077

CERTIFICATE OF DEATH

17070

1. PLACE OF DEATH
a. COUNTY: CHARLES
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PHYSICIANS MEMORIAL HOSP.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HUGHESVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edna Middle MAE Last Montgomery
4. DATE OF DEATH: Month Dec. Day 18 Year 1966
5. SEX: Female
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 25, 1907
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (County & State or foreign country): CHARLES MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM BASSFORD
14. MOTHER'S MAIDEN NAME: MARTHA G. MONTGOMERY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: PAUL B. MONTGOMERY, Address HUGHESVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): MYOCARDIAL INFARCTION — Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 6 APRIL, 1965 to 16 DEC, 1966, that (I) (~~saw~~) last saw the deceased alive on 16 DEC 1966, and that death occurred at 10:05 A.M. from causes and on the date stated above

22a. SIGNATURE: J. Barry Mason MD — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 18 Dec 66
22c. PHYSICIAN'S NAME (Type): J. G. Barry Mason
22d. ADDRESS: Jarwood Clinic, La Plata, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-21-66
23c. NAME OF CEMETERY OR CREMATORY: ST MARYS CEM.
23d. LOCATION (City or Town) (County) (State): BRYANTOWN, MD.
24. FUNERAL DIRECTOR: HUNTT FUNERAL HOME, WALDORF, MD
ADDRESS:
25a. REC'D BY REGISTRAR DATE: DEC 23 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17078

CERTIFICATE OF DEATH

17071

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WALDORF
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WALDORF
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ALBERT — Middle ERIC — Last PETZOLD
4. DATE OF DEATH: Month Dec — Day 27 — Year 1966
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-27-1903
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): IRON WORKER
10b. KIND OF BUSINESS OR INDUSTRY: IRON WORKS
11. BIRTHPLACE (County & State, or foreign country): LINDENAU, GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ROBERT PETZOLD
14. MOTHER'S MAIDEN NAME: ALVINE WENZELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 579-09-7144
17. INFORMANT — Address: Willy Petzold, WALDORF, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 20 MIN.
DUE TO (b): ANGINA — 2 years.
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
I420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from April, 1958, to 12-27, 1966, that (I) (we) last saw the deceased alive on 12-23 1966, and that death occurred at 10 A.M., from causes and on the date stated above.

22a. SIGNATURE: F. M. Johnson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-28-66
22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D.
22d. ADDRESS: LA PLATA, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-30-66
23c. NAME OF CEMETERY OR CREMATORY: OAKLAND CEM.
23d. LOCATION (City or Town) (County) (State): WALDORF, CHARLES, MD.
24. FUNERAL DIRECTOR — ADDRESS: HUNTT FUNERAL HOME, WALDORF, MD.
25a. REC'D BY REGISTRAR — DATE: JAN 3 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and for any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17079

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17072

1 PLACE OF DEATH
a COUNTY Charles MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
c LENGTH OF STAY IN To
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE VA b COUNTY Caroline
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Royal
d. STREET ADDRESS
e IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print) First Bernard Middle Lost
4 DATE OF DEATH Month Day Year
5 SEX
6 COLOR OR RACE
7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH Dec 27 1927
9. AGE (In years last birthday) 38 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) VA
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James T. Powers
14. MOTHER'S MAIDEN NAME Edith Gouldman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service
16 SOCIAL SECURITY NO
17 INFORMANT Address VA
Mann Funeral Home, Bowling Green

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7/16/1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
Emergency

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, or Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county)
22. DATE SIGNED 12-

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 12-11-66
23c. NAME OF CEMETERY OR CREMATORY St. Peters
23d LOCATION (City or Town) Port Royal (County) Caroline (State) VA.

24 FUNERAL DIRECTOR Mann Funeral Home
ADDRESS VA. Bowling Green
25a. RECD BY REGISTRAR DATE DEC 12 1966
25b REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17080

CERTIFICATE OF DEATH

17073

1. PLACE OF DEATH a. COUNTY: CHARLES, MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA	c. LENGTH OF STAY IN 1b: 12 hrs.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Forest	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PHYSICIANS MEMORIAL HOSPITAL	d. STREET ADDRESS: 3516 56th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒	

3. NAME OF DECEASED (Type or print) First: JOHN Middle: LOUIS Last: Scheibach	4. DATE OF DEATH Month: December Day: 4, Year: 1966
5. SEX: Male	6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Feb 21, 1896
9. AGE (In years last birthday): 70 yrs	IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Draftsman	10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (County & State, or foreign country): Wisconsin	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frederick Scheibach	14. MOTHER'S MAIDEN NAME: Christine Moran
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I	16. SOCIAL SECURITY NO.
17. INFORMANT: Grace J. Scheibach, Address: Cheverly Forest Md	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: 331X

		Interval between onset and death
IMMEDIATE CAUSE (a)	Cerebrovascular Accident	
DUE TO (b)	Carotid thrombosis, right	12 hrs.
DUE TO (c)	Arteriosclerotic Vascular Disease	Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 3 Dec, 1966, to 4 Dec, 1966, that (I) (~~we~~) last saw the deceased alive on 4 Dec 1966, and that death occurred at 3:25 AM, from causes and on the date stated above.

22a. SIGNATURE: J. Barry Mason M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4 Dec 66

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: La Plata, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Dec 7, 1966	23c. NAME OF CEMETERY OR ~~CREMATORY~~: Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons	ADDRESS: Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE: DEC 6 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

By Deputy Medical Examiner Dr. James Andrews, notified by J. Barry Mason MD — O.K'd release

VR A15 (R) 20 M 1/66

1 (IV)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17074

1. PLACE OF DEATH
   a. COUNTY: Charles — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanjemoy
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Charles
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanjemoy
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: IOLA — Middle: — Last: THOMPSON

4. DATE OF DEATH: Month: December — Day: 21 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 23,1880

9. AGE (In years last birthday): 86 yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Charles Co.,Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Thompson

14. MOTHER'S MAIDEN NAME: Clarinda Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): No

16. SOCIAL SECURITY NO: --

17. INFORMANT — Address: Irene Dunbar,Nanjemoy,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracerebral Hemorrhage.
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o m p m 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from. Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]
Address (Street, city, town, or county):

22. DATE SIGNED: 12/22/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec.23,1966

23c. NAME OF CEMETERY OR CREMATORY: Chicamuxen M.E.

23d. LOCATION (City or Town) (County) (State): Chicamuxen,Charles,Md.

24. FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home Inc.,La Plata,Md.

25a. RECD BY REGISTRAR DATE: DEC 30 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17082

CERTIFICATE OF DEATH

17075

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HUGHESVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HUGHESVILLE 08.1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First NICHOLAS — Middle AUGUSTINE — Last TOLLA
4. DATE OF DEATH: Month 12 — Day 28 — Year 1966

5. SEX: MALE
6. COLOR OR RACE: CAU.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-6-1897
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: TOBACCO
11. BIRTHPLACE (County & State, or foreign country): AUSTRIA, HUNGARY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS TOLLA
14. MOTHER'S MAIDEN NAME: JULIA ABFALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-36-6713
17. INFORMANT: MARY CONNICK — Address: AQUASCO MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arterio-sclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot ~~(I) (this~~ haspital) attended the deceased from _____, 19___, to _____, 19___, thot (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at _____M, from causes and on the date stated above.

22a. SIGNATURE: J. D. Williams M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/28/66
22c. PHYSICIAN'S NAME (Type): R. de VILLARREAL
22d. ADDRESS: St Leonard, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-31-66
23c. NAME OF CEMETERY OR CREMATORY: ST MARYS CEM.
23d. LOCATION (City or Town) (County) (State): BRYANTOWN, MD.

24. FUNERAL DIRECTOR: Hunter Funeral Home — ADDRESS: Waldorf, Md
25a. REC'D BY REGISTRAR DATE: JAN 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pleds (carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17083

CERTIFICATE OF DEATH

17076

1. PLACE OF DEATH
a. COUNTY: Charles — b. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rison
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): P.O Address: Rt 1 Box 407 Indian Head Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pisgah
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jodnd (Drury) — Middle: — Last: Wood
4. DATE OF DEATH: Month: December — Day: 3 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 22 1876
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): St. Mary's County Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Levi Drury
14. MOTHER'S MAIDEN NAME: Mary Jane Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 215-07-0938
17. INFORMANT: Mrs Julian Delozier
Address: Rt. 1 Box 407 Indian Head Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: Immediate

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Heart Disease — 20 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1940 to 12/3 1966 that (I) (we) last saw the deceased alive on Nov. 19 1966, and that death occured at 4:30 PM from the causes and on the date stated above.

22a. SIGNATURE: Frank A Jason M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/3/66
22c. PHYSICIAN'S NAME (Type): Frank A. Jason M.D
22d. ADDRESS: Rt. 1 Box 50, Indian Head Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-3-66
23c. NAME OF CEMETERY OR CREMATORY: ST CHARLES CEM.
23d. LOCATION (City, town or county) (State): INDIAN HEAD, MD.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HUNTT FUNERAL HOME, WALDORF, MD
25a. REC'D BY REGISTRAR DATE: DEC 7 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60